STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	07/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTH CARE CENTER	333 W MISHAWAKA RD ELKHART, IN46517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: June 27-July 1 and July 5-6, 2011 Facility number: 000523 Provider number: 155496 AIM number: 100266930 Survey team: Honey Kuhn, RN, TC Carol Miller, RN Census bed type: SNF/NF: 106 Total: 106 Census payor type: Medicare: 12 Medicaid: 74 Other: 20 Total: 106 Sample: 22 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 7/11/11 by Suzanne Williams, RN	F0000	This facility requests that this plan of correction be considered it's credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Correction as a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure the accurate dosage of Morphine Sulfate was administered as ordered for 1 of 22 residents reviewed for medications in a sample of 22. (Resident #109) Finding includes: The closed record of Resident #109 was reviewed on 07/05/11 at 2:15 p.m. Resident #109 was admitted to the facility on 11/29/10 with diagnoses including, but not limited to, CHF (congestive heart failure), renal failure, and osteoarthritis. The resident was admitted to a hospital on 06/16/11 and returned to the facility on 06/21/11 at 1:30 p.m. with Hospice services arranged for end of life care and services. Review of a physician's order indicated: "06/22/11 Morphine 10 mg (milligrams)/5 ml (milliliters): 30 cc (vial) 2.5 ml q (every) 2 hr (hour) PRN (as needed) muscular skeletal pain." Review of a hand written MAR (Medication Administration Record), dated 06/22/2011-06/30/2011, indicated: "Morphine 10 mg/5 ml: 30 cc (vial) 2.5 ml q 2* (hour) PRN muscular skeletal	F0333	**F333 Residents Free of Significant Med Errors I. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The affected resident no longer resides at the facility. **II. How have other residents having the potential to be affected by the same deficient practice been identified and what corrective actions will be taken for those residents:** a. A whole-house audit was performed by contracted Pharmacy Services from July 11, 2011 to July 18, 2011 to compare each resident's Medication Administration Record (MAR) with the medications in the medication carts for that resident. (Attachment A) b. Issues identified in the audit were corrected and family, resident, or POA and physician was made aware. **III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** a. Licensed Nurses will complete a Medication to Medication Administration Record Comparison each time they receive new medication for a resident. This will be done *before* the medication is loaded into the medication cart. Nurses will	08/02/2011

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	pain". (5 mg=2.5 ml) In addition, the MAR indicated: "Morphine 100 mg/5 ml 0.25 ml q 2* PRN for muscular skeletal pain" (5 mg=.25 ml) Review of "Resident Progress Notes" indicated: "06/24/11 (late entry for 1600 [4:00 p.m.]): Medication variance noted. DNS (Director Nursing Services), MD (Medical Doctor), ED (Executive Director) notified. Family @ (at) bedside. N.O. (New Order) to check O2 (oxygen) sat (saturation) & (and) resp (respirations) q 15 min (minutes) X 2* then q hr X 4*. Wait 4* 'til (until) next dose. Call EMS resp < (less than: per minute) 12 or sat < 88%. B/P (blood pressure) 122/54, P (pulse) 108, R (respiration) 16, O2 sat on 2 L/MN (2 liters/minute) = 91 %." "06/24/11 1645 (4:45 p.m.) Spoke c (with) family regarding N/O (new order) to send to ER if family wished. They stated they would like her to stay @ facility. Resident lying in bed c eyes closed. Resp even et (and) unlabored @ this time." The documentation indicated Resident #109 continued to be monitored as ordered with respirations at a rate of 10 recorded twice. The family remained at		complete "MEDICATION CARD TO MAR AUDIT" (Attachment B) log each time they intake medications and must sign to show that the audit has been completed and the medications match the Medication Administration Record. If there is a discrepancy, they must immediately notify the Unit Manager PRIOR to giving the medication or stocking it into the med cart. Clarification will be sought as needed and medications returned to the pharmacy as needed. b. Licensed nurses and QMAs were inserviced by Staff Development Coordinator regarding proper Medication Administration techniques. (Attachment C.) .c. PharMerica has instituted a new process for any concentration change of Morphine Liquid Prescriptions (Attachment D). This process change took effect on July 6, 2011 and was communicated to all PharMerica staff on the same day. The process change is as follows: For any change of concentration in Morphine Liquid Prescriptions: A copy of the new written prescription or the physician telephone order must be printed. The word "VOID" must be written boldly across the face of the new order or prescription and this copy must be attached to the newly dispensed medication. PharMerica staff must document this change of concentration with	

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	the bedside throughout the course of the resident's stay. The resident continued to receive PRN pain medication as ordered. The resident expired on 06/26/11 at 1850 (6:50 p.m.). The DNS was interviewed on 07/06/11 at 8:30 a.m. in regards to the "variance". The DNS indicated Resident #109 received Morphine Sulfate 100 mg/5 ml dose of 2.5 ml, or 50 mg, rather than the transcribed .25 ml, or 5 mg, as ordered. The DNS indicated the pharmacy would normally notify the facility and mark the medication as different concentration as prescribed. The DNS indicated the medication was administered by a QMA (Qualified Medication Aide) after the resident was assessed by LPN #3 as the facility protocol requires. The DNS indicated the QMA noted the discrepancy following the administration of the medication when recording on the MAR and immediately notified LPN #3, who in turn notified the appropriate staff. The DNS provided a copy of the vial sent by the pharmacy which read: "Morphine Sulfate oral solution. 100 mg per 5 ml (20 mg/ml). The label did not indicate the Morphine was other than the physician's order of Morphine 10 mg/5 ml. Review of a Policy and Procedure, titled,		the nurse's name, date and time. **IV. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** a. Unit Managers will check MARs daily (Monday through Friday) to ensure that "MEDICATION CARD TO MAR AUDIT" (Attachment B) is being completed as medications are stocked, and that any discrepancies have been reported and clarified or corrected prior to medication administration or stocking. This will continue for a period of three months, with weekly checks thereafter. b. Director of Nursing Services or her designee will perform a weekly review of "MEDICATION CARD TO MAR AUDIT" (Attachment B) logs for each unit to ensure they have been completed and that discrepancies have been followed up and clarification has been sought. This will continue for a period of three months, with monthly checks thereafter. c. Director of Nursing Services or her designee will audit one resident's medications per week to ensure that the Medication Administration Record and the Medications in the Medication Cart for that resident match. The MEDICATION CARD TO MAR AUDIT (Attachment B) will be used for this audit. This will continue for a period of three	

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	"Medication Administration: 10/31/10", provided by the DNS at the time, indicated: "Procedure: Preparation to Medication Administration:.. 7. Prepare the medication using the five rights of mediation administration: Right patient, Right medication name and strength, and Right time of administration, Right frequency Right route of administration... 10. Prepare the medication. a. Read the medication record order(s) and compare with the prescription label(s)... c. Read the medication orders(s), and again compare with the prescription label(s)..." 3.1-25(b)(9) 3.1-48(c)(2)		months, with monthly audits thereafter. d. Results of Audits will be presented to the Performance Improvement Committee monthly for a period of six months for review with extension of review period as needed. Determination for need of extension will be based on incidents of non-compliance with auditing or continued issue with incorrect dosage / concentration of medication delivered from pharmacy as determined by results of auditing and monitoring. **V. Completion Date: 8-2-11**	

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F0425 SS=D	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.			
	Based on record review and interview, the facility failed to ensure the dosage of Morphine Sulfate was clearly labeled and administered as ordered for 1 of 22 residents reviewed for medications in a sample of 22. (Resident #109) Finding includes: The closed record of Resident #109 was reviewed on 07/05/11 at 2:15 p.m. Resident #109 was admitted to the facility on 11/29/10 with diagnoses including, but not limited to, CHF (congestive heart failure), renal failure, and osteoarthritis. The resident was admitted to a hospital on 06/16/11 and returned to the facility on 06/21/11 at 1:30 p.m. with Hospice	F0425	**F 425 Pharmaceutical SVC-Accurate Procedures I. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Affected Resident no longer resides in the facility. **II. How have other residents having the potential to be affected by the same deficient practice been identified and what corrective actions will be taken for those residents:** a. A whole-house audit was performed by contracted Pharmacy Services from July 11, 2011 to July 18 , 2011 to compare each resident's Medication Administration Record (MAR) with the medications in the medication carts for that	08/02/2011

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	services arranged for end of life care and services. Review of a physician's order indicated: "06/22/11 Morphine 10 mg (milligrams)/5 ml (milliliters): 30 cc (vial) 2.5 ml q (every) 2 hr (hour) PRN (as needed) muscular skeletal pain." Review of a hand written MAR (Medication Administration Record), dated 06/22/2011-06/30/2011, indicated: "Morphine 10 mg/5 ml: 30 cc (vial) 2.5 ml q 2* (hour) PRN muscular skeletal pain". (5 mg=2.5 ml) In addition, the MAR indicated: "Morphine 100 mg/5 ml 0.25 ml q 2* PRN for muscular skeletal pain" (5 mg=.25 ml) Review of "Resident Progress Notes" indicated: "06/24/11 (late entry for 1600 [4:00 p.m.]): Medication variance noted. DNS (Director Nursing Services), MD (Medical Doctor), ED (Executive Director) notified. Family @ (at) bedside. N.O. (New Order) to check O2 (oxygen) sat (saturation) & (and) resp (respirations) q 15 min (minutes) X 2* then q hr X 4*. Wait 4* 'til (until) next dose. Call EMS resp < (less than: per minute) 12 or sat < 88%. B/P (blood pressure) 122/54, P (pulse) 108, R (respiration) 16, O2 sat on		resident. (Attachment A) b. Issues identified in the audit were corrected and family, resident, or POA and physician was made aware. **III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** a. Licensed Nurses will complete a Medication to Medication Administration Record Comparison each time they receive new medication for a resident before the medication is loaded into the medication cart. Nurses will complete "MEDICATION CARD TO MAR AUDIT" (Attachment B) log each time they intake medications and must sign to show that the audit has been completed and the medications match the Medication Administration Record. If there is a discrepancy, they must immediately notify the Unit Manager PRIOR to giving the medication or stocking it into the med cart. Clarification will be sought as needed and medications returned to the pharmacy as needed. b. Licensed nurses and QMAs were inserviced by the Staff Development Coordinator regarding proper Medication Administration techniques. (Attachment C.) c Medication Errors will be reviewed by Nursing Management as they occur to determine cause of error, if possible. Clarification or	

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	2 L/MN (2 liters/minute) = 91 %." "06/24/11 1645 (4:45 p.m.) Spoke c (with) family regarding N/O (new order) to send to ER if family wished. They stated they would like her to stay @ facility. Resident lying in bed c eyes closed. Resp even et (and) unlabored @ this time." The documentation indicated Resident #109 continued to be monitored as ordered with respirations at a rate of 10 recorded twice. The family remained at the bedside throughout the course of the resident's stay. The resident continued to receive PRN pain medication as ordered. The resident expired on 06/26/11 at 1850 (6:50 p.m.). The DNS was interviewed on 07/06/11 at 8:30 a.m. in regards to the "variance". The DNS indicated Resident #109 received Morphine Sulfate 100 mg/5 ml dose of 2.5 ml, or 50 mg, rather than the transcribed .25 ml, or 5 mg, as ordered. The DNS indicated the pharmacy would normally notify the facility and mark the medication as different concentration as prescribed. The DNS indicated the medication was administered by a QMA (Qualified Medication Aide) after the resident was assessed by LPN #3 as the facility protocol requires. The DNS		correction of orders will occur as needed and staff re-education will occur as needed. d PharMerica has instituted a new process for any concentration change of Morphine Liquid Prescriptions (Attachment D). This process change took effect on July 6, 2011 and was communicated to all PharMerica staff on the same day. The process change is as follows: For any change of concentration in Morphine Liquid Prescriptions: A copy of the new written prescription or the physician telephone order must be printed. The word “VOID” must be written boldly across the face of the new order or prescription and this copy must be attached to the newly dispensed medication. PharMerica staff must document this change of concentration with the nurse’s name, date and time. **IV. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place :** a. Unit Managers will check MARs daily (Monday through Friday) to ensure that “MEDICATION CARD TO MAR AUDIT” (Attachment B) is being completed as medications are stocked, and that any discrepancies have been reported and clarified or corrected prior to medication administration or stocking. This will continue for a period of three months, with	

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	indicated the QMA noted the discrepancy following the administration of the medication when recording on the MAR and immediately notified LPN #3, who in turn notified the appropriate staff. The DNS provided a copy of the vial sent by the pharmacy which read: "Morphine Sulfate oral solution. 100 mg per 5 ml (20 mg/ml). The label did not indicate the Morphine was other than the physician's order of Morphine 10 mg/5 ml. Review of a Policy and Procedure, titled, "Medication Administration: 10/31/10", provided by the DNS at the time, indicated: "Procedure: Preparation to Medication Administration:.. 7. Prepare the medication using the five rights of mediation administration: Right patient, Right medication name and strength, and Right time of administration, Right frequency Right route of administration... 10. Prepare the medication. a. Read the medication record order(s) and compare with the prescription label(s)... c. Read the medication orders(s), and again compare with the prescription label(s)...		weekly checks thereafter. b. Director of Nursing Services or her designee will perform a weekly review of "MEDICATION CARD TO MAR AUDIT" (Attachment B) logs for each unit to ensure they have been completed and that discrepancies have been followed up and clarification has been sought. This will continue for a period of three months, with monthly checks thereafter. c. Director of Nursing Services or her designee will audit one resident's medications per week to ensure that the Medication Administration Record and the Medications in the Medication Cart for that resident match. The MEDICATION CARD TO MAR AUDIT (Attachment B) will be used for this audit. This will continue for a period of three months, with monthly audits thereafter. d. Results of Audits will be presented to the Performance Improvement Committee monthly for a period of six months for review with extension of review period as needed. Determination for need of extension will be based on incidents of non-compliance with auditing, review of medication error rate reveals it is above expected threshold, or continued issue with incorrect dosage / concentration of medication delivered from pharmacy as determined by results of auditing and monitoring. **V. Completion**	

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			Date: 8-2-11	

Review of a Policy and Procedure, titled, "Medication Labels and Packaging: 10/31/09", provided by the DNS at the time, indicated:
"Procedure: 1. Validate that each prescription medication label includes:
a. Resident's name
b. Specific directions for use, including route of administration.
c. Medication name
d. Strength/concentration of medications...

2. Reject improperly, inaccurately labeled medications...

4. If the physician's directions for use change or the label is inaccurate, place a "change of order-check chart" label on the container..."

Review of a Policy and Procedure, titled, "Pharmacy Services: 02/23/11", provided by the DNS at the time, indicated:
"Compliance Guidelines:...
3. The pharmacy agrees to accurately dispense prescriptions based on authorized prescriber orders....

10. The pharmacy screens each new medication order for:...
d. appropriate medication dose, dosing interval, and the route of administration ...

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	11. Pharmacy reports any irregularities that could result in a significant negative outcome to the center and/or subscriber...." 3.1-25(g)(1) 3.1-25(l)(5)			
F0502 SS=E	The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on record reviews and interviews, the facility failed to ascertain the laboratory tests were obtained as ordered by physicians for 5 of 22 residents reviewed for diagnostic tests in a sample of 22. (Residents #85, #104, #36, #67, and #76) Findings include: 1. The record of Resident #85 was reviewed on 06/30/11 at 10:00 a.m. and indicated diagnoses including, but not limited to, diabetes, Parkinson's, anemia, and hypertension. Review of a Physician's Order Sheet, for 06/2011, indicated: "02/10/2011: creat/alb ratio (a specific urine test) annually." The record did not contain the lab result.	F0502	**F502 Administration (The facility must provide or obtain laboratory services to meet the needs of it's residents) I. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** a. Physicians, Residents and/or Family/POAs of Residents affected were informed of labs that were not obtained per physician's order. b. Order clarification was received for each resident regarding the ordered lab and labs were obtained as ordered. **II. How have other residents having the potential to be affected by the same deficient practice been identified and what corrective actions will be taken for those residents:** a. Whole house laboratory audit was contracted with South Bend Medical Foundation and completed on	08/02/2011

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	Interview with the North Unit Manager, at the time, indicated she was unaware the test was not done. 2. The record of Resident #104 was reviewed on 06/29/11 at 9:00 a.m. and indicated diagnoses including, but not limited to, diabetes, CAD (coronary artery disease), hypertension, morbid obesity, and anemia. Review of a Physician's Order Sheet, for 06/2011, indicated: "08/04/2010: micro/creat ratio (a specific urine test) annually" "07/05/2010: CBC w/o diff (with/out differential: without a breakdown of components) and CMP monthly X 3 then quarterly (4 times a year.) The record did not contain the lab results. Interview with the North Unit Manager, on 06/29/11 at 5:10 p.m., indicated the facility discovered the labs were not completed during a QA (Quality Assurance: a means to track and trend resident care issues) in 03/2011 and the physician was notified at the time the micro creatinine was not done as well as the CMP's for 07/2010, 08/2010, 09/2010, and 12/2010. 3. The record of Resident #36 was reviewed on 07/01/11 at 11:00 a.m., and indicated diagnoses including but not limited to, dementia, depression,		6-28-11. (Attachment E) b. Audit of all lab orders obtained after the South Bend Medical Foundation Audit was completed by the Unit Managers on 7-15-11. (Attachment F) c. Any errors or omissions identified by the audit process will be corrected and family, resident or POA and physicians made aware. **III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** a. Licensed nurses were inserviced by Staff Development Coordinator regarding lab order procedures and new process of recording routine labs on the MEDICATION ADMINISTRATION RECORD. (Attachment G) b. All current and new routine lab orders will be added to the MEDICATION ADMINISTRATION RECORD and will be signed out by licensed nurse as the labs are completed. c Unit Managers will maintain 2 year calendars with all routine labs listed in the months they are due. Unit Managers will maintain and review these on a daily basis (Monday through Friday) to ensure that routine labs are completed as ordered. d MEDICATION ADMINSTRATION RECORDS will be reviewed monthly by Medical Records and a Licensed Nurse during end of the month “change over” to ensure that no scheduled routine lab orders are “dropped” from the	

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	155496	A. BUILDING 00 B. WING	07/06/2011

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	hypertension and hypothyroidism. Review of a Physician's Order Sheet, dated 05/2011, indicated: "09/30/2008 TSH (Thyroid Stimulating Hormone) quarterly." The record contained a TSH dated 10/15/10. Interview with the North Unit Manager, at the time, indicated the Resident #36 had a recent history of refusing ordered lab tests and provided information the resident refused a blood draw on 04/15/11. The Unit Manager was unaware the record did not contain a lab result for a 01/2011 TSH. Review of a facility Policy and Procedure, provided by a corporate DNS on 07/05/11 at 8:30 a.m., titled, "Renewed or Recapitulated (Recap) Physician's Orders, Medication Records, and Treatment Records: 10/31/06" indicated: "Rationale: Every 30 days physician's orders are validated that physician orders are clear, complete, and signed.... Physician's orders are reviewed and revised..." "Procedure:...2. Validate the physician's orders for accuracy. 3. Review new recapped orders with the old current orders...."		MAR. **IV. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place :** a. Director of Nursing Services will review Unit Managers Lab Calenders on a weekly basis and perform a random audit of at least one resident per unit per week to ensure that scheduled labs were completed as ordered and results of the lab are located on the resident's chart. Weekly audits will continue for a period of three months, with monthly audits to continue thereafter. b Results of Audits will be presented to the Performance Improvement Committee monthly for a period of six months for review with extension of review as needed. Extention of review will be based on results of DNS lab calender review. If no scheduled routine lab orders are "dropped" from the MAR or not obtained as ordered, PI review will discontinue. **V. Completion Date: 8-2-11**	

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	4. The record of Resident #67 was reviewed on 7/1/11 at 9:15 a.m., indicated Resident # 67's diagnoses included, but were not limited to, diabetes, hypertension, and urinary retention. A. The Physician's Order Sheet dated 6/1/11, indicated an order dated 4/20/11 for a Hemoglobin A1C (a laboratory test for diabetes) to be drawn every three months. The laboratory tests in the resident's chart were reviewed and was unable to locate the April 2011 Hemoglobin A1C laboratory test. Interview on 7/5/11 at 10:00 a.m., with the South Unit Manager RN in regard to the April 2011 Hemoglobin A1C (HGB A1C) laboratory test. The South Unit Manager RN indicated the laboratory test for HGB A1C got missed and unsure why the Hemoglobin A1C was not drawn back in April 2011. The South Unit Manager RN further indicated Resident #67's Physician was notified on 7/1/11 and an order was received to obtain the HGB A1C laboratory test. The Hemoglobin A1C laboratory test result that was obtained was dated 7/1/11			

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	at 1740 (5:40 p.m.). B. The Physician's Order dated 6/8/11 indicated to obtain annually the laboratory test for"microalb/creat" laboratory test (Microalbumin/Creatinine Ratio). The Microalbumin/Creatinine Ratio laboratory test was dated as obtained on 6/14/11. On 7/1/11 at 10:30 a.m., interview with the South Unit Manager RN in regard to the Microalbumin/Creatinine Ratio laboratory test not done until 6/14/11, and the South Unit Manager indicated when the first laboratory sample was obtained and sent to the laboratory the Nurse had marked the incorrect test to be obtained. The South Unit Manager further indicated the Nurse had marked the laboratory request form for an urinary analysis test and not as a Microalbumin/Creatinine Ratio test. 5. The record of Resident #76 was reviewed on 6/29/11 at 10:15 a.m., and indicated Resident #76's diagnosis included, but were not limited to, chronic embolism and thrombosis. The Physician's Order dated 5/25/11 indicated to obtain on 5/31/11 a Prothrombin/ International Ratio (a			

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	laboratory test for blood clotting) (PT/INR). The laboratory tests in Resident #76's chart were reviewed and was unable to find a PT/INR laboratory test result for 5/31/11. On 6/29/11 at 2:00 p.m., the South Unit Manager was interviewed in regard to the 5/31/11 PT/INR laboratory test and indicated the resident's Physician was notified on 6/2/11 that the PT/INR was not drawn on 5/31/11, and a new Physician's Order was received to obtain the laboratory test on 6/6/11. On 7/6/11 at 8:30 a.m., the South Unit Manager was interviewed in regard to the PT/INR laboratory test not done on 5/31/11 and indicated the PT/INR laboratory test was not placed on the Treatment Administration Record for 5/31/11 and as a result the laboratory test got missed. The PT/INR laboratory test result drawn on 6/6/11 indicated the Prothrombin Time (PT) was elevated at 12.4, normal range is 9.0 to 12.0. The PT/INR laboratory test result dated 6/6/11 indicated the current order for coumadin (a medication to prevent blood			

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	clots) was administrate Coumadin 10 milligrams times 1 day and alternate with coumadin 7.5 milligrams times 3 days was changed to coumadin 7.5 milligrams times 2 days and alternate with coumadin 10 milligrams 1 day. 3.1-49(a)			